SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
VERIFICATION OF REAL AND PERSONAL PROPERTY

From: (Name & Address of DHHS Office)	**Date:**
	Eligibility Worker:
	Telephone:
To: (Name & Address of Custodian of Records)	**Primary Individual's Name:**
	Household Number:

Please complete a property search on the individuals listed below. As a public service agency we regret that we are unable to pay for your assistance.

IDENTIFYING INFORMATION	
Name of Medicaid Applicant/Beneficiary:	**Residence Address:**
Parents	
Mother:	**Spouse:**
Date of Death:	**Date of Death:**
Father:	**Spouse:**
Date of Death:	**Date of Death:**
Other Relative(s):	
Known Information Pertaining to Properties:	

COURTHOUSE SEARCH--AUDITOR'S/ASSESSOR'S OFFICE

Real Property (Include property in which individual has a life estate.) ☐ **No Record Found**

Owner(s)	**Description (Include Street Address)**	**Appraised Value (FMV)**	**Date of Last Assessment**

Personal Property (Cars, boats, mobile homes, etc.) ☐ **No Record Found**

Owner(s)	**Year**	**Make**	**Model**	**Registration Date**	**Vehicle ID Number**

I authorize any custodian of records named above to disclose to the South Carolina Department of Health and Human Services (DHHS) any records or information about my real or personal property or that of the person(s) named below whom I legally represent or whose benefits I manage.

SIGNATURE OF APPLICANT/BENEFICIARY	**DATE**

SIGNATURE (DHHS OFFICIAL)	**DATE**

PROBATE COURT	
Wills/Estates	☐ **No Record Found**

Power of Attorney/Committee/Guardian:

Register of Mesne Conveyance or Clerk of Court					
Property transfers during the past _____ months.			☐ **No Record Found**		
Grantor	**Grantee**	**Deed Book & Page**	**Date of Deed**	**Description of Property**	**Sale Price**

COMMENTS

Date Checked:	☐ **No Record Found**

NAME OF AGENCY/CUSTODIAN OF RECORD(S)	**SIGNATURE OF RESEARCHER**	**TELEPHONE NUMBER**